DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 3 — 0 3

2. STATE: Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
X XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 447

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 ($4,261,050) (Hosp.)
b. FFY 2004 ($3,023,128) (Rehab.)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B, pp. 4, 4.1 of 15
Supplement 5 to Attachment 4.19B, p. 1 of 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
same pages
new page

10. SUBJECT OF AMENDMENT:
Limit Outpatient Hospital Payments to 80% Allowable Costs
Prospective Reimbursement for Rehabilitation Agencies

GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Secretary, Health & Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[signature]

13. TYPED NAME:
Patrick W. Finnerty

14. TITLE:
Director, DMAS

15. DATE SUBMITTED:
August 8, 2003

16. RETURN TO:
Dept. of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Attn.: Regulatory Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
8/11/04

18. DATE APPROVED:
MAR 5 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
7/1/03

20. SIGNATURE OF REGIONAL OFFICIAL:
[signature]

21. TYPED NAME:
MARY T. MCSORLEY

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID & CHILDREN'S HEALTH

23. REMARKS:

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE-
OTHER TYPES OF CARE

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12 VAC 30-80-200. Prospective reimbursement for rehabilitation agencies.

A. Effective for dates of service on and after July 1, 2003, rehabilitation agencies, excluding those operated by Community Services Boards, shall be reimbursed a prospective rate equal to the lesser of the agency's cost per visit for each type of rehabilitation service (physical therapy, occupational therapy, and speech therapy) or a statewide ceiling established for each type of service. The prospective ceiling for each type of service shall be equal to 112% of the weighted median cost per visit, for such services, of rehabilitation agencies. The weighted median shall be calculated using a base year to be determined by the Department. The weighted median calculated and effective July 1, 2003, and the resulting ceiling, shall be applicable to all services beginning on and after July 1, 2003, and all services in provider fiscal years beginning in SFY2004.

B. In each provider fiscal year, each provider's prospective rate shall be determined based on the cost report from the previous year and the ceiling, calculated by DMAS, that is applicable to the state fiscal year in which the provider fiscal year begins.

C. For providers with fiscal years that do not begin on July 1, 2003, services for the fiscal year in progress on that date shall be apportioned between the time period before and the time period after that date based on the number of calendar months before and after that date. Costs apportioned before that date shall be settled based on allowable costs, and those after shall be settled based on the prospective methodology.

D. Beginning with state fiscal years beginning on and after July 1, 2004, the ceiling and the provider specific cost per visit shall be adjusted for inflation, from the previous year to the prospective year, using the nursing facility inflation factor published for Virginia by DRI, applicable to the calendar year in progress at the start of the state fiscal year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE-
OTHER TYPES OF CARE

(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ICD-9-CM diagnosis codes and necessary supporting documentation.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

c. Limitation to 80% of allowable cost. Effective for services on and after July 1, 2003, reimbursement of Type Two hospitals for outpatient services shall be at 80% of allowable cost, with cost to be determined as provided in A, B, and C above. For hospitals with fiscal years that do not begin on July 1, 2003, outpatient costs, both operating and capital, for the fiscal year in progress on that date, shall be apportioned between the time period before and the time period after that date, based on the number of calendar months in the cost reporting period, falling before and after that date. Operating costs apportioned before that date shall be settled according to the principles in effect before that date, and those after at 80% of allowable cost. Capital costs apportioned before that date shall be settled according to the principles in effect before that date, and those after at 80% of allowable cost. Operating and capital costs of Type One hospitals shall continue to be reimbursed at 94.2% and 90% of cost respectively.

d. For outpatient hospital services prior to July 1, 2003 , DMAS shall reimburse for these services, with the exception of direct graduate medical education for interns and residents, at 100% of reasonable costs less a 10% reduction for capital costs and a 5.8% reduction for operating costs.

(1) Direct medical education costs of nursing schools and paramedical programs shall continue to be paid on an allowable cost basis.

(2) Effective with cost reporting periods beginning on or after July 1, 2002, direct Graduate Medical Education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis. See 12 VAC 30-70-281 for prospective payment methodology for graduate medical education for interns and residents.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE-
OTHER TYPES OF CARE

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e. Payment for direct medical education costs of nursing schools, paramedical programs and graduate medical education for interns and residents.

(1) Direct medical education costs of nursing schools and paramedical programs shall continue to be paid on an allowable cost basis.

(2) Effective with cost reporting periods beginning on or after July 1, 2002, direct graduate medical education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis. See 12 VAC 30-70-281 for prospective payment methodology for graduate medical education for interns and residents.

3. Rehabilitation agencies operated by Community Services Boards. For the reimbursement methodology applicable to other rehabilitation agencies, see Attachment 4.19-B, Supplement 5 (12 VAC 30-80-200). Reimbursement for physical therapy, occupational therapy, and speech-language therapy services shall not be provided for any sums that the rehabilitation provider collects, or is entitled to collect, from the NF or any other available source, and provided further, that this amendment shall in no way diminish any obligation of the NF to DMAS to provide its residents such services, as set forth in any applicable provider agreement.

4. Comprehensive outpatient rehabilitation facilities.

5. Rehabilitation hospital outpatient services.

6. Supplemental payments to non-state government-owned hospitals for outpatient services.
   a. Subject to legislative authorization as required and the availability of local, State, and Federal funds, and based upon a transfer agreement and the subsequent transfer of funds, the Department provides quarterly lump sum supplemental payments to participating non-state government-owned hospitals for outpatient services provided to Medicaid patients on or after December 16, 2001. The supplemental payments are made from a pool of funds, the amount of which is the difference between the Medicaid payments otherwise made to the qualifying hospitals for outpatient services to Medicaid patients and the maximum amount allowable under applicable federal regulations at 42 CFR 447.321.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE-
OTHER TYPES OF CARE

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b. A qualifying hospital is owned or operated by a unit of government other than a state. The payment amount for a qualifying hospital participating according to the provisions in subsection 6A above is the hospital's proportionate share of the established pool of funds determined by dividing the participating hospital's payment for outpatient services provided to Medicaid patients during the most recent fiscal year by the total payments for outpatient services to Medicaid patients provided by all qualifying hospitals for the same fiscal year.

c. A payment made to a hospital under this provision when combined with other payments made under the state plan shall not exceed the limit specified in 42 CFR 447.325.

7. Supplemental payments to state government-owned hospitals for outpatient services.

a. Subject to legislative authorization as required and the availability of State and federal funds, and based upon a transfer agreement and the subsequent transfer of funds, DAMS shall provide lump sum supplemental payments to participating state government-owned hospitals for outpatient services provided to Medicaid patients on or after July 1, 2002. The supplemental payments are made from a pool of funds, the amount of which is the difference between the Medicaid payments otherwise made to the qualifying hospitals for outpatient services to Medicaid patients and the maximum amount allowable under applicable federal regulations at 42 CFR 447.321.

b. A qualifying hospital is owned or operated by the state. The payment amount for a qualifying hospital participating according to the provisions in subsection 7a above is the hospital's proportionate share of the established pool of funds determined by dividing the hospital's payments for outpatient services provided to Medicaid patients during the most recent fiscal year by the total payments for outpatient services to Medicaid patients provided by all qualifying hospitals for the same fiscal year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE-
OTHER TYPES OF CARE

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c. A payment made to a hospital under this provision when combined with other payments made under the state plan shall not exceed the limit specified in 42 FFR 447.325.

5.1. Inpatient psychiatric inpatient psychiatric services in residential treatment facilities (under EPSDT). Effective January 1, 2000, payment will be made for inpatient psychiatric services in residential treatment facilities using a per diem payment rate as determined b the state agency based on information submitted by enrolled residential psychiatric treatment facilities. This rate shall constitute payment for all residential psychiatric treatment facility services, excluding all professional services.